

# National Provider Identifier Providers

The information below is a list of important fields on the CMS-1500 claim form for providers who bill using an NPI number. Fields not listed below are not needed to process a claim for Montana Medicaid.

## Member Has Medicaid Coverage Only

<b>CMS-1500</b>		
Field #	Field Title	Instructions
<b>Member Information</b>		
2*	Member's Name	Enter patient's name as seen on member's Montana Health Care Programs information.
10d, *	Member's ID	Enter the member's ID number as it appears on the member's Montana Health Care Programs information.
1a, 9a, 11**	Member's ID	If member's ID is not located in 10d, these three fields are searched for the number.
<b>Provider Information</b>		
17a**	Referring Provider's Passport #	Enter referring provider's Passport number if a Passport member (a qualifier is not necessary).
17b**	Referring Provider's NPI	Enter referring provider's NPI.
19**	Reserved for Local Use	For CSCT schools, enter TEAM followed by the team number.
24a shaded	NDC	Enter the qualifier, N4, followed by the NDC (NDC should not have punctuation, dashes or spaces), units qualifier and units as described by the qualifier.
24i shaded**	ID Qualifier	<b>ZZ</b> for the taxonomy qualifier.
24j shaded**	Taxonomy Code	Enter the taxonomy code for the rendering provider.
24j **	NPI Number, Rendering Prov	Enter NPI number for the rendering provider.
31*	Signature and Date	Enter signature and date.
33*	Billing Provider Info	Enter physical address with a 9-digit ZIP code and phone number.
33a*	NPI #	Enter NPI number for billing/pay-to provider.
33b*	Taxonomy #	Enter the qualifier (ZZ) and the billing provider's taxonomy code.
<b>Billing Information</b>		
21.1–21.4*	Diagnosis codes	Enter at least one diagnosis.
24a*	Dates of Service	Enter the dates of service include beginning and ending date even if same.
24b*	Place of Service	Enter the code for place of service.
24c**	EMG	Emergency indicator if applicable.
24d*	Procedure Code	Enter the procedure code used/Enter modifiers if applicable.
24e*	Diagnosis Pointer	Enter the corresponding diagnosis pointer (1, 2, 3 ,or 4) that refers to the codes in field 21.
24f*	Charges	Enter the total charge for this line.
24g*	Days/Units	Enter the days or units used for the procedure.
24h**	EPSDT Family Plan	Enter 1 when the member is under age 21. Enter 2 when providing family planning services. Enter 3 when the member is under age 21 and is receiving family planning services. Enter 4 when providing services to pregnant women. Enter 6 when providing services to nursing facility residents.
28*	Total Charges	Enter total charges from all line items.

\* = Required Field

\*\* = Conditional (Required if applicable)

Rendering required if pay-to (billing) is one of the following:

- Podiatry Clinic
- Physical Therapist Clinic
- Speech Therapist Clinic
- Occupational Therapist Clinic
- Dental Clinic
- Physician Clinic
- Dedicated Emergency Department
- General Group or Clinic
- Provider Based Clinics
- Hospitals
- FQHC
- RHC

1500

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

## Medicaid Only Coverage — Healthcare Providers

Fill Colors (shaded areas are slightly darker):

- Required Fields
- Conditional Fields
- Other

Border Colors

- Client Fields
- Provider Fields
- Billing Fields

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Flintstone, Fred T										3. PATIENT'S BIRTH DATE MM DD YY 08 30 60 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street) 112 Rocky Rd. CITY: Bedrock STATE: BC ZIP CODE: 54321-1234 TELEPHONE (Include Area Code): (406) 765-4321										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) CITY: STATE: ZIP CODE: TELEPHONE (Include Area Code): ( )																																							
8. PATIENT STATUS Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Other <input type="checkbox"/> Employed <input checked="" type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>										9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO d. RESERVED FOR LOCAL USE 123456789										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME Medicaid d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, return to and complete item 9 a-d.																													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED: DATE:																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED:																																							
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 01 01 07										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Great Gazoo MD										17a. 9954321 17b. NPI 1234567890										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 285.21 2. 3. 4. 24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER																																																	
1 N4 55513009701 ML1 01 01 07 01 01 07 11 J0881 1 1500 00 500 6 ZZ 36LP00000X 01 01 07 01 01 07 11 J0881 1 1500 00 500 6 NPI 1213456789																																																											
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25. FEDERAL TAX I.D. NUMBER 99-9999999										26. PATIENT'S ACCOUNT NO. 123456789										27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 1500 00										29. AMOUNT PAID \$										30. BALANCE DUE \$ 1500 00									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Rocky Shalestone, MD 01/01/07										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. 33. BILLING PROVIDER INFO & PH # (406) 555-1234 Yabba-Dabba Center 2121 Granite Slab Dr. Bedrock, BC 54321-1234 a. 9876543210 b. ZZ.400RT0010X																																																	